CONFERENCE ON SCHOOL HEALTH EDUCATION
Sponsored by California State Department of Education
State Department of Public Health
University of California, Berkeley
July 22-25, Inc., 1940

A Conference on School Health Education, sponsored by the State Departments of Education and Public Health, will be conducted during the summer session on the University of California campus in Berkeley by Dr. Mayhew Derryberry, Chief of Health Education Studies, National Institute of Health, United States Public Health Service.

Dates of the Conference are July 22 to 25, inclusive. The program is planned to be of value to educators and to workers in public health. Lectures will be interspersed with showings of new motion pictures, exhibits of educational materials and field trips to clinics, child-health conferences, public-health laboratories, and other places of interest.

Doctor Derryberry will conduct discussions on problems which arise in introducing units of health instruction in other courses, on values and limitations of special hygiene courses and on the evaluation of school health education.

Lectures by other experts in the fields of education and public health will deal with school health education services and materials available in California from federal and local sources, the control of communicable diseases, and problems of nutrition.

For further information and registration, write Conference on School Health Education, Haviland Hall, University of California, Berkeley, California.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Unfortunate Results of Eye Operation Not a Ground of Liability

A recent California case, *Adams* vs. *Boyce, et al.*, 100 Cal. App. Dec. 794, is one case which should be of interest to the profession at large, because of the manner in which certain well-established rules of law relating to malpractice cases were applied.

On the morning of November 27, 1935, plaintiff, while using a carpenter's wrecking bar, suddenly felt something strike his right eye. Upon looking into a mirror and observing a small red spot in the extreme right corner of the eye, plaintiff went to Santa Monica where he had three x-ray films taken of his eye. The same afternoon he consulted one of the defendant doctors who examined the eye and attempted to secure the use of a giant magnet from a hospital. He was unsuccessful because he was not a member of the hospital staff. The following day, plaintiff attempted to obtain treatment at the General Hospital of Los Angeles. At that institution another x-ray was taken by another defendant doctor. While at the hospital, plaintiff met a third doctor (also a defendant), with whom he talked concerning the injury. Plaintiff was refused treatment at the hospital and on November 29 went to the California Hospital and was admitted as a patient. At one o'clock and again at three o'clock of that afternoon, plaintiff telephoned to the doctor he had met at the county hospital (Doctor B) and at the latter time, after informing the doctor that no x-rays had as yet been taken, plaintiff was told to put on his clothes and come down to the doctor's office. From that point he was taken to the office of another defendant doctor in the same building, at which place x-rays were taken. Later in the same day plaintiff returned to the hospital and at five o'clock was taken into the operating room.

Concerning the operation, plaintiff testified as follows:

Upon arrival at the operating room, one Dr. R., still another defendant, washed around the area of his eye and covered his left eye with a bandage. Dr. B. then stuck something into plaintiff's upper and lower lids and proceeded to hold a pair of scissors up above his eye. Plaintiff felt a twisting motion on his side and all of a sudden there was a give and it seemed like he pushed something into the eye. Plaintiff said that all during this time his eye was looking straight up. Dr. B. then asked the nurse for the magnet, and plaintiff heard a humming sound. Pretty soon Dr. B. said, "I can't find it and it isn't magnetic." Plaintiff testified that he stated to Drs. B. and R. that the steel chip hit the eye way over on one side and that the first redness appeared over on the side and that x-rays disclosed it to be lodged over on the side. Dr. B. asked the nurse for something and he squeezed it into plaintiff's eye, wiped it out and put a patch on.

Dr. B. described the operation in substance as follows: After the eye was anesthetized, the conjunctiva was picked up approximately over the foreign body and was dissected back over the foreign body, exposing the sclera. Then a little opening was made in the wall of the eye with a cataract knife, just a tiny, little opening, and then the magnet was put up against this opening and the current turned on. That was done at least a dozen times and no foreign body came. Dr. B. testified: "After I saw that the magnet was not going to pull the foreign body, I took a tiny, little pair of iris scissors and introduced the tip end of the scissors about four millimeters. I did that in preference to putting the tip of the magnet, because the magnet is a great big thing and would have enlarged the wound. I put the scissors into the little opening almost in contact with the foreign body and then touched them with the magnet."

On the morning of December 2, Dr. B. took plaintiff to the office of another defendant, Dr. I., where the two doctors looked into plaintiff's eye with an ophthalmoscope and saw the foreign body still within the eye. On the following Thursday plaintiff's eye was swollen shut, whereupon he went to Dr. B., who looked into the eye without an instrument and, according to plaintiff, said, "My God! Something's happened! You have panophthalmitis," and suggested that plaintiff go to a local hospital for injection of foreign protein and then keep hot applications on his eye, two hours on and one off, for ten days. Plaintiff testified that Dr. B. stated he could do no more for plaintiff and that the latter should go to Santa Monica and get taken care of locally. Plaintiff subsequently lost the use of the eye.

From the facts above stated, the Court held that of all the various defendants none could be held liable. A nonsuit was granted in favor of Dr. J., one of the roentgenologists, because there was no evidence at all of any negligence on his part. The Court held that there was also no evidence of any negligence on the part of the other roentgenologists. In regard to Drs. B. and R. and the defendant hospital, the Court stated:

> Assuming that the record presented a case of mistaken diagnosis, it is totally lacking in any incidents of carelessness or unskillfulness necessary to constitute actionable negligence. When due care, diligence, judgment, and skill are exercised, a mere failure to diagnose correctly does not render a physician liable."

The Court further stated that in the present case it was impressed with the fact that plaintiff had not even proved a mistaken diagnosis.

The Court reiterated the well-settled rule of *Hesler* vs. *California Hospital Co.*, 178 Cal. 764, where it was said that the law requires of the physician only

> First, that he shall have the degree of learning and skill ordinarily possessed by physicians of good standing practicing in that locality, and, second, that he shall exercise reasonable and ordinary care and diligence in treating the patient and in applying such learning and skill to the case. The law takes cognizance of human weakness and liability to err in the application of skill and learning, and it requires only the exercise of reasonable and ordinary care and diligence to avoid error.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.